EXHIBIT D

CKC MEDICAL OFFICE P.C.

CHAN, CHUN-KIT, MD

2 MOTT ST SUITE #305 825 57th Street Suite #203
NY NY 10013 BROOKLYN NY 11220
Tel: 212-791-6968 Tel: 718-676-0269
Fax: 212-791-6983 Fax: 718-676-0270

NAME: ZENG, XIA MIN GENDER: Female DOB: 09/09/1981 AGE AS OF 04/21/2018: 36y
ADDRESS: 110 Columbia St Apt 1A NEW YORK NY 10002 TEL: 929-250-4690
OFFICE VISIT DATE: 04/21/2018 Time: 01:46:00 PM

Chief Complaint
Source of History: Patient Reliability: Good
Reason for Visit:
COUGH, FATIGUE
DECREASE HEARING,
History of Present Illness:
C/O COUGH & RHINORRHEA X 2 DAYS, ASSOCIATED WITH CONGESTED NSOE AND SNEEZING; FELT FEVERISH NO CHILLS; DENY GI/URINARY SYMPTOMS; NO SHORTNESS OF BREATH; (+) MILD THROAT DISCOMFORT.
C/O ON AND OFF EPISODE OF HEARING LOST OVER LAST MONTH, NO DIZZINESS VERTIGO, HEADACHE, TINNITIS,

Review of Systems:
Constitution:
See HPI
Cardiovas:
Denies chest pain, palpitations, jaw pain, shoulder pain, anxiety, or diaphoresis .
ENT:
See HPI
GI:
Denies abdominal pain, difficulty with swallowing, heart burn, BRPBP, melana, or changes in bowel habbits .
Head/Neck:
Denies neck pain or stiffness, noticeable nodes, or mass on neck .
Muscular/Skeletal:
Denies joint pain, swelling, muscle weakness, unilateral deficits, or fatigue .
Resp:
See HPI

Physical Exam Detail:
Nose/Sinus:

(+) CONGESTION OF THE NASAL MUCOSA; SWOLLEN IN APPEARANCE; NO MEMBRANE ABRASION, NO POLYP, NO BLEEDING, POST NASAL DRIP.
Throat/Mouth:

(+)MILD TO MODERATE INJECTION OF PHARYNX WITH MILD TONSILAR ENLARGEMENT; NO EXUDATE; NO ULCERLATION.
Ears:
Normal hearing; No discharge; External canal is intact; Tympamic membrane is intact; No bulging; No fluid/blood collection.
Chest/Lung:
Chest wall movement is symmetric with respiration; No intercostal retraction; No tendeness/fremitus; Breath sounds are clear; No rales/wheezing.
Heart:
Heart rate is within nomal limit; Regular rhythm; First heart sound and second heart sound present; No murmurs/thrills.
Abdomen:
Soft; No distended; Non-tendeness; No palpable mass; No hepatomegaly/splenomegaly; Costovertebral angle is nontendeness; No inquinal hernia/lymphe nodes.
Extremities:
No deformity/clubbing/cyanosis/edema; Bilateral pedal pulse present; No visible joint swelling/erythema; Normal ROM.

Allergy:
Medication

No Known Medication Allergy
Food
No known Food Allergy
Environmental
No known Environmental Allergy

Vital Signs:
Date: 04/21/2018 02:54 PM, HT: 5'2.5" (ft/inches), WT: 130 (lbs/oz), BP: 123/77 (mmHg), HR: 77 (/min), RR: 12 (/min), Temp: 98 (F), BMI: 23.4

Diagnosis Code:
(1) Acute upper respiratory infection, unspecified (J06.9)
(2) Unspecified hearing loss, unspecified ear (H91.90)

Procedure Code:
(1) OFFICE/OUTPATIENT VISIT EST (99213)

Prescription:
(1) Claritin-D 12 Hour 5-120 MG Oral Tablet Extended Release 12 Hour SIG: TAKE 1 TAB P.O. BID Disp: 30 Tablet Refill: 0 Printed
(2) Tylenol 325 MG Oral Tablet SIG: 1 po q4h prn Disp: 30 Tablet Refill: 0 Printed

Assessment/Plan:
ADEQUATE FLUID INTAKE,

POTENTIAL MEDICATION SIDE-EFFECTS DICCUSSED IN DETAIL; PT VERBALIZED UNDERSTANDING AND ACCEPTANCE OF ASSOCIATED BENEFITS/RISKS.
REFER TO ENT,
RTC IF SYMPTOM PERSIST,
Procedure:
ASSESSES PATIENT/FAMILY/CAREGIVER'S:

ABILITY TO UNDERSTAND CONCEPTS AND CARE REQUUIREMENTS ASSOCIATING WITH MANAGING PATIENT'S HEALTH: YES

PATIENT VOICES UNDERSTANDING OF ALL CONCEPTS DISCUSSED DURING THEIR VISIT INCLUDING CARE MANAGEMENT, MEDICATION, PATIENT EDUCATION: YES

Attending Provider: CHAN, CHUN-KIT, MD, Covering Provider: CHAN, CHUN-KIT, MD
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Fax: 718-676-0270

NAME: ZENG, XIA MIN GENDER: Female DOB: 09/09/1981 AGE AS OF 10/03/2018: 37y
ADDRESS: 110 Columbia St Apt 1A NEW YORK NY 10002 TEL: 929-250-4690
OFFICE VISIT DATE: 10/03/2018 Time: 03:29:00 PM

Chief Complaint
- Source of History: Patient Reliability: Good
- Reason for Visit:
  - COUGH, FATIGUE
- History of Present Illness:
  - C/O COUGH & RHINORRHEA X 5 DAYS, ASSOCIATED WITH WHITISH SPUTUM, NO FEVER/CHILLS; DENY GI/URINARY SYMPTOMS; NO SHORTNESS OF BREATH; (+) MILD THROAT DISCOMFORT.

Review of Systems:
- Constitution:
  - See HPI
- Cardiovas:
  - Denies chest pain, palpitations, jaw pain, shoulder pain, anxiety, or diaphoresis .
- ENT:
  - See HPI
- GI:
  - Denies abdominal pain, difficulty with swallowing, heart burn, BRPBP, melana, or changes in bowel habbits .
- Head/Neck:
  - Denies neck pain or stiffness, noticeable nodes, or mass on neck .
- Muscular/Skeletal:
  - Denies joint pain, swelling, muscle weakness, unilateral deficits, or fatigue .
- Resp:
  - See HPI

Physical Exam Detail:
- Nose/Sinus:
  - *(+) CONGESTION OF THE NASAL MUCOSA; SWOLLEN IN APPEARANCE; NO MEMBRANE ABRASION, NO POLYP, NO BLEEDING, POST NASAL DRIP.*
- Throat/Mouth:
  - *(+)MILD TO MODERATE INJECTION OF PHARYNX WITH MILD TONSILAR ENLARGEMENT; NO EXUDATE; NO ULCERLATION.*
- Chest/Lung:
  - Chest wall movement is symmetric with respiration; No intercostal retraction; No tendeness/fremitus; Breath sounds are clear; No rales/wheezing.
- Heart:
  - Heart rate is within nomal limit; Regular rhythm; First heart sound and second heart sound present; No murmurs/thrills.
- Abdomen:
  - Soft; No distended; Non-tendeness; No palpable mass; No hepatomegaly/splenomegaly; Costovertebral angle is nontendeness; No inquinal hernia/lymphe nodes.
- Extremities:
  - No deformity/clubbing/cyanosis/edema; Bilateral pedal pulse present; No visible joint swelling/erythema; Normal ROM.

Allergy:
- Medication
  - No Known Medication Allergy
- Food
  - No known Food Allergy
- Environmental
  - No known Environmental Allergy

Vital Signs:

Date: 10/03/2018 04:01 PM, HT: 5'2.5" (ft/inches), WT: 128 (lbs/oz), BP: 132/77 (mmHg), HR: 77 (/min), RR: 12 (/min), Temp: 98 (F), BMI: 23.04

Diagnosis Code:
(1) Acute upper respiratory infection, unspecified (J06.9)

Procedure Code:
(1) OFFICE/OUTPATIENT VISIT EST (99213)

Prescription:
(1) Bromfed DM 30-2-10 MG/5ML Oral Syrup SIG: Take 10 ml by mouth every 4 hours as needed for cough Disp: 1 Bottle Refill: 0 Printed
(2) Tylenol 325 MG Oral Tablet SIG: 2 tab po q4h prn Disp: 30 Tablet Refill: 0 Printed

Assessment/Plan:
ADEQUATE FLUID INTAKE,
RTC IF SYMPTOM PERSIST,
Procedure:
ASSESSES PATIENT/FAMILY/CAREGIVER'S:

ABILITY TO UNDERSTAND CONCEPTS AND CARE REQUUIREMENTS ASSOCIATING WITH MANAGING PATIENT'S HEALTH: YES

PATIENT VOICES UNDERSTANDING OF ALL CONCEPTS DISCUSSED DURING THEIR VISIT INCLUDING CARE MANAGEMENT, MEDICATION, PATIENT EDUCATION: YES

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NAME: ZENG, XIA MIN GENDER: Female DOB: 09/09/1981 AGE AS OF 10/16/2018: 37y
ADDRESS: 110 Columbia St Apt 1A NEW YORK NY 10002 TEL: 929-250-4690
OFFICE VISIT DATE: 10/16/2018 Time: 01:02:00 PM

Chief Complaint
Source of History: Patient Reliability: Good
Reason for Visit:
SORE THROAT
History of Present Illness:
CAME IN DUE TO SORE THROAT FOR 3 DAYS. ASSOCIATED WITH COUGHING, YELLOWISH SPUTUM, AND HEADACHE, ASSOCIATED WITH FEVER, NO CHILLS / ABDOMINAL PAINS. DENY FATIGUE.
PT WENT TO ED THIS AM, SHE REFUSED CXR AND SIGN OUT AMA , HERE FOR MED,

Review of Systems:
Constitution:
See HPI
Cardiovas:
Denies chest pain, palpitations, jaw pain, shoulder pain, anxiety, or diaphoresis .
ENT:
See HPI
GI:
Denies abdominal pain, difficulty with swallowing, heart burn, BRPBP, melana, or changes in bowel habbits .
Head/Neck:
Denies neck pain or stiffness, noticeable nodes, or mass on neck .
Muscular/Skeletal:
Denies joint pain, swelling, muscle weakness, unilateral deficits, or fatigue .
Resp:
See HPI

Physical Exam Detail:
Nose/Sinus:

(+) CONGESTION OF THE NASAL MUCOSA; SWOLLEN IN APPEARANCE; NO MEMBRANE ABRASION, NO POLYP, NO BLEEDING, POST NASAL DRIP.
Throat/Mouth:

(+)MODERATE INJECTION OF PHARYNX WITH MILD TONSILAR ENLARGEMENT; WHITISH EXUDATE; NO ULCERLATION.
Chest/Lung:
Chest wall movement is symmetric with respiration; No intercostal retraction; No tendeness/fremitus; Breath sounds are clear; No rales/wheezing.
Heart:
Heart rate is within nomal limit; Regular rhythm; First heart sound and second heart sound present; No murmurs/thrills.
Abdomen:
Soft; No distended; Non-tendeness; No palpable mass; No hepatomegaly/splenomegaly; Costovertebral angle is nontendeness; No inquinal hernia/lymphe nodes.
Extremities:
No deformity/clubbing/cyanosis/edema; Bilateral pedal pulse present; No visible joint swelling/erythema; Normal ROM.

Allergy:
Medication
No Known Medication Allergy
Food
No known Food Allergy
Environmental
No known Environmental Allergy

Vital Signs:
Date: 10/16/2018 02:49 PM, BP: 132/66 (mmHg), HR: 66 (/min), RR: 12 (/min), Temp: 98 (F)

Diagnosis Code:
(1) Acute pharyngitis, unspecified (J02.9)

Procedure Code:
(1) OFFICE/OUTPATIENT VISIT EST (99212)

Prescription:
(1) Amoxicillin 500 MG Oral Capsule SIG: 1 po tid Disp: 21 Tablet Refill: 0 Printed
(2) Dimetapp DM Cold/Cough 2.5-1-5 MG/5ML Oral Liquid SIG: 15ml po q6h prn Disp: 8 Fluid Ounce Refill: 0 Printed
(3) Tylenol 325 MG Oral Tablet SIG: 1 po q4h prn Disp: 30 Tablet Refill: 0 Printed

Assessment/Plan:
GARGGLE WITH SALT WATER,
ADEQUATE FLUID INTAKE,

POTENTIAL MEDICATION SIDE-EFFECTS DICCUSSED IN DETAIL; PT VERBALIZED UNDERSTANDING AND ACCEPTANCE OF ASSOCIATED BENEFITS/RISKS.
RTC IF SYMPTOM PERSIST,
Procedure:
ASSESSES PATIENT/FAMILY/CAREGIVER'S:

ABILITY TO UNDERSTAND CONCEPTS AND CARE REQUUIREMENTS ASSOCIATING WITH MANAGING PATIENT'S HEALTH: YES

PATIENT VOICES UNDERSTANDING OF ALL CONCEPTS DISCUSSED DURING THEIR VISIT INCLUDING CARE MANAGEMENT, MEDICATION, PATIENT EDUCATION: YES

Attending Provider: CHAN, CHUN-KIT, MD, Covering Provider: CHAN, CHUN-KIT, MD
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NAME: ZENG, XIA MIN GENDER: Female DOB: 09/09/1981 AGE AS OF 10/24/2018: 37y
ADDRESS: 110 Columbia St Apt 1A NEW YORK NY 10002 TEL: 929-250-4690
OFFICE VISIT DATE: 10/24/2018 Time: 11:19:00 AM

Chief Complaint
Source of History: Patient Reliability: Good
Reason for Visit:
COUGH,
History of Present Illness:
C/O RECURRENT COUGH FOR 2 WEEKS ON AND OFF, BUT FELT MUCH BETTER, S/P ANTIBIOTIC, RAN OUT COUGH MED, FELT ITCHY THROAT, NO SNEEZING, RUNNY NOSE, NO WT LOST, DOE, SOB, HEMOPTYSIS, NIGHT SWEAT, DOE

Review of Systems:
Constitution:
See HPI
Cardiovas:
Denies chest pain, palpitations, jaw pain, shoulder pain, anxiety, or diaphoresis .
ENT:
See HPI
GI:
Denies abdominal pain, difficulty with swallowing, heart burn, BRPBP, melana, or changes in bowel habbits .
Head/Neck:
Denies neck pain or stiffness, noticeable nodes, or mass on neck .
Muscular/Skeletal:
Denies joint pain, swelling, muscle weakness, unilateral deficits, or fatigue .
Resp:
See HPI

Physical Exam Detail:
Throat/Mouth:

(+)MILD TO MODERATE INJECTION OF PHARYNX WITH MILD TONSILAR ENLARGEMENT; NO EXUDATE; NO ULCERLATION.
Nose/Sinus:
Symmetric; No obstruction; No nasal flaring/grunting.
Chest/Lung:
Chest wall movement is symmetric with respiration; No intercostal retraction; No tendeness/fremitus; Breath sounds are clear; No rales/wheezing.
Heart:
Heart rate is within nomal limit; Regular rhythm; First heart sound and second heart sound present; No murmurs/thrills.
Abdomen:
Soft; No distended; Non-tendeness; No palpable mass; No hepatomegaly/splenomegaly; Costovertebral angle is nontendeness; No inquinal hernia/lymphe nodes.
Extremities:
No deformity/clubbing/cyanosis/edema; Bilateral pedal pulse present; No visible joint swelling/erythema; Normal ROM.

Allergy:
Medication
No Known Medication Allergy
Food
No known Food Allergy
Environmental
No known Environmental Allergy

Vital Signs:
Date: 10/24/2018 11:40 AM, BP: 131/82 (mmHg), HR: 71 (/min), RR: 14 (/min), Temp: 97.7 (F)

Diagnosis Code:
(1) Cough (R05)

Procedure Code:
(1) OFFICE/OUTPATIENT VISIT EST (99212)

Prescription:
(1) Dimetapp DM Cold/Cough 2.5-1-5 MG/5ML Oral Liquid SIG: 15ml po q6h prn Disp: 8 Fluid Ounce Refill: 0 Sent

Assessment/Plan:
ADEQUATE FLUID INTAKE,
RTC IF SYMPTOM PERSIST,
Procedure:
ASSESSES PATIENT/FAMILY/CAREGIVER'S:

ABILITY TO UNDERSTAND CONCEPTS AND CARE REQUUIREMENTS ASSOCIATING WITH MANAGING PATIENT'S HEALTH: YES

PATIENT VOICES UNDERSTANDING OF ALL CONCEPTS DISCUSSED DURING THEIR VISIT INCLUDING CARE MANAGEMENT, MEDICATION, PATIENT EDUCATION: YES

Attending Provider: CHAN, CHUN-KIT, MD, Covering Provider: CHAN, CHUN-KIT, MD
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NAME: ZENG, XIA MIN GENDER: Female DOB: 09/09/1981 AGE AS OF 11/28/2018: 37y
ADDRESS: 110 Columbia St Apt 1A NEW YORK NY 10002 TEL: 929-250-4690
OFFICE VISIT DATE: 11/28/2018 Time: 02:27:00 PM

Chief Complaint
Source of History: Patient Reliability: Good
Reason for Visit:
FLU VACCINE

COUGH,
History of Present Illness:

CAME IN FOR FLU VACCINE TODAY; NO EGG ALLERGY, NO FEVER, NO URI,

C/O COUGH FOR 2 DAYS ON AND OFF, FELT ITCHY THROAT, NO SNEEZING, RUNNY NOSE, TOOK OTC COUGH MEDS WITHOUT RELEIVED, NO WT LOST, DOE, SOB, HEMOPTYSIS, NIGHT SWEAT, DOE

Review of Systems:
Constitution:
See HPI
Cardiovas:
Denies chest pain, palpitations, jaw pain, shoulder pain, anxiety, or diaphoresis .
ENT:
See HPI
GI:
Denies abdominal pain, difficulty with swallowing, heart burn, BRPBP, melana, or changes in bowel habbits .
Head/Neck:
Denies neck pain or stiffness, noticeable nodes, or mass on neck .
Muscular/Skeletal:
Denies joint pain, swelling, muscle weakness, unilateral deficits, or fatigue .
Resp:
See HPI

Physical Exam Detail:
Nose/Sinus:
Symmetric; No obstruction; No nasal flaring/grunting.
Throat/Mouth:
No oral ulcer; Pharynx is clear; No erythematous; No exudate; No foreign body seen; No gum swelling/bleeding.
Chest/Lung:
Chest wall movement is symmetric with respiration; No intercostal retraction; No tendeness/fremitus; Breath sounds are clear; No rales/wheezing.
Heart:
Heart rate is within nomal limit; Regular rhythm; First heart sound and second heart sound present; No murmurs/thrills.
Abdomen:
Soft; No distended; Non-tendeness; No palpable mass; No hepatomegaly/splenomegaly; Costovertebral angle is nontendeness; No inquinal hernia/lymphe nodes.
Extremities:
No deformity/clubbing/cyanosis/edema; Bilateral pedal pulse present; No visible joint swelling/erythema; Normal ROM.

Allergy:
- Medication
  - No Known Medication Allergy
- Food
  - No known Food Allergy
- Environmental
  - No known Environmental Allergy

Vital Signs:
Date: 11/28/2018 02:40 PM, BP: 123/77 (mmHg), HR: 78 (/min), RR: 12 (/min), Temp: 98 (F)

Diagnosis Code:
(1) Cough (R05)
(2) Encounter for immunization (Z23)

Procedure Code:
(1) OFFICE/OUTPATIENT VISIT EST (9921325)
(2) CCIIV4 VACCINE PRESERVATIVE FREE 0.5 ML IM USE (90674)
(3) IMMUNIZATION ADMIN (90471)

Prescription:
(1) Tessalon Perles 100 MG Oral Capsule SIG: 1 Tablet By Mouth BID Disp: 30 Capsule Refill: 0 Sent

Assessment/Plan:
Encounter for immunization:
FLU SHOT X 1 DOSE GIVEN FLUCELVAX QUADRIVALENT 0.5 CC IM FROM SEQIRUS.
LOT # 253823, EXP DATE-6/30/2019

Other Plan/Conclusion
ADEQUATE FUID INTAKE,
RTC IF SYMPTOM PERSIST,
Procedure:
ASSESSES PATIENT/FAMILY/CAREGIVER'S:

ABILITY TO UNDERSTAND CONCEPTS AND CARE REQUUIREMENTS ASSOCIATING WITH MANAGING PATIENT'S HEALTH: YES

PATIENT VOICES UNDERSTANDING OF ALL CONCEPTS DISCUSSED DURING THEIR VISIT INCLUDING CARE MANAGEMENT, MEDICATION, PATIENT EDUCATION: YES

Attending Provider: CHAN, CHUN-KIT, MD, Covering Provider: CHAN, CHUN-KIT, MD
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NAME: ZENG, XIA MIN GENDER: Female DOB: 09/09/1981 AGE AS OF 12/17/2018: 37y
ADDRESS: 110 Columbia St Apt 1A NEW YORK NY 10002 TEL: 929-250-4690
OFFICE VISIT DATE: 12/17/2018 Time: 02:06:00 PM

Chief Complaint
- Reason for Visit:
  - PHYSICAL EXAM
- History of Present Illness:
  - CAME IN FOR PHYSICAL EXAM TODAY, NO SPECIFIC COMPLAINT AT PRESENT TIME. DENY REGULAR EXERCISE BUT DENY DYSPNEA ON EXERTION OR CHEST PAINS WITH DAILY ACTIVITIES.

Review of Systems:
- Constitution:
  - Denies fever, chills, fatigue, or unexpected weight changes .
- Allergy/Immun:
  - Denies skin rash or other any other signs of an allergic reaction .
- Cardiovas:
  - Denies chest pain, palpitations, jaw pain, shoulder pain, anxiety, or diaphoresis .
- Endocrine:
  - Denies hot flashes, feeling cold, mood changes, or glove size changes .
- ENT:
  - Denies hearing loss, change of vision, pain, discharge of nose or ear, dizziness, or sinus pressure .
- Eyes:
  - Denies visual changes, eye pain, or redness .
- GI:
  - Denies abdominal pain, difficulty with swallowing, heart burn, BRPBP, melana, or changes in bowel habbits .
- Head/Neck:
  - Denies neck pain or stiffness, noticeable nodes, or mass on neck .
- Heme/Lym:
  - Denies swollen glands, bleeding problems, or bruising.
- Muscular/Skeletal:
  - Denies joint pain, swelling, muscle weakness, unilateral deficits, or fatigue .
- Neuro:
  - Denies headache, passing out, generalized or unilateral numbness, tingling sensation, facial droop, slurred speech, or drooling .
- Psych:
  - Denies panic disorder, depression, or anxiety .
- Resp:
  - Denies shortness of breath, cough, hemoptysis, wheezes, or sputum production .
- Skin:
  - Denies skin or hair changes .

Physical Exam Detail:
- Head/Scalp/Face:
  - Normal cephalic; Nontraumatic skull; No tendeness; No palpable mass.
- Eyes:
  - Normal conjuntiva; No jaundice; Pupils are symmetric, normal size with active light reflex.
- Ears:
  - Normal hearing; No discharge; External canal is intact; Tympamic membrane is intact; No bulging; No fluid/blood collection.
- Nose/Sinus:
  - Symmetric; No obstruction; No nasal flaring/grunting.
- Throat/Mouth:
  - No oral ulcer; Pharynx is clear; No erythematous; No exudate; No foreign body seen; No gum swelling/bleeding.
- Neck:
  - Range of motion is within normal limit; No tendeness; No jugular venous distention; No lymph nodes/mass palpable; There is no goiter/bruits on thyroid exam.

Chest/Lung:
Chest wall movement is symmetric with respiration; No intercostal retraction; No tendeness/fremitus; Breath sounds are clear; No rales/wheezing.
Heart:
Heart rate is within nomal limit; Regular rhythm; First heart sound and second heart sound present; No murmurs/thrills.
Abdomen:
Soft; No distended; Non-tendeness; No palpable mass; No hepatomegaly/splenomegaly; Costovertebral angle is nontendeness; No inquinal hernia/lymphe nodes.
Extremities:
No deformity/clubbing/cyanosis/edema; Bilateral pedal pulse present; No visible joint swelling/erythema; Normal ROM.
Skin/Membrane:
Skin warm to touch; Normal color; No laceration/bruise; No rash/eczema/ulcers.
Neurological:
Alert and awake, oriented to time, name and place; No focal deficit; Cranial nerves gross intact; No gait disturbance; No tremors.
Muscular:
Normal tone; No muscular atrophy/hypertrophy; No jerking.
Mental Status:
Dress neat and clean; No mood swing; No memory loss.

Allergy:
Medication
No Known Medication Allergy
Food
No known Food Allergy
Environmental
No known Environmental Allergy

Vital Signs:
Date: 12/17/2018 02:31 PM, HT: 5'2.5" (ft/inches), WT: 133 (lbs/oz), BP: 118/73 (mmHg), HR: 78 (/min), RR: 12 (/min), Temp: 97.1 (F), BMI: 23.94, Pain Level: 0 (Pain/10 10=worst)

Diagnosis Code:
(1) Encntr for general adult medical exam w/o abnormal (Z00.00)
(2) Encounter for screening, unspecified (Z13.9)
(3) Body mass index (BMI) 23.0-23.9, adult (Z68.23)

Procedure Code:
(1) PREV VISIT EST AGE 18-39 (99395)
(2) VITAL SIGNS RECORDED (2010F)
(3) SCREEN DEPRESSION PERFORMED (3725F)
(4) PT INELIG NEG SCRN DEPRES (G8510)
(5) ALCOHOL/DRUG SCREENING (H0049)
(6) ROUTINE VENIPUNCTURE (36415)
(7) URINALYSIS NONAUTO W/O SCOPE (81002)
(8) MED LIST DOCD IN RCRD (1159F)
(9) AMNT PAIN NOTED NONE PRSNT (1126F)
(10) TOBACCO NON-USER (1036F)
(11) SYST BP LT 130 MM HG (3074F)
(12) DIAST BP <80 MM HG (3078F)
(13) CALC BMI NORM PARAMETERS (G8420)

Assessment/Plan:
Encntr for general adult medical exam w/o abnormal:
Lifestyle Changes:
Regardless of which treatment you get, you will need to make lifestyle changes. You can reduce or prevent symptoms such as angina by working on reducing your heart disease risk factors.

These include the following:
Smoking: Smoking is a high risk factor for development and progression of heart disease since it causes stiffening of blood vessels. Our practice offers many smoking cessation techniques and counseling. Talk to us about quitting.

High Cholesterol: Know your cholesterol numbers and ask your doctor if you've optimized them to the recommended levels. Fatty deposits cause stiffening of the arteries.

Nutrition: Eat a healthy diet with limited amounts of saturated fat, eat lots of whole grains, and many fruits and vegetables.

Physical Activity: Together with your doctor start a safe exercise plan. Because angina is often brought

on by exertion, it's helpful to pace yourself and take rest breaks.

Excess Weight: Excess weight is a high risk factor in Coronary Artery Disease. Losing weight decreases your risk. Monitor your weight and report sudden changes in weight to your doctor of more than two pounds in as many days as this may signal fluid retention.

Underlying Conditions: Treat diseases or conditions that can increase your risk of angina, such as diabetes, high blood pressure and high blood cholesterol. Make sure to adhere to your treatment plans including all medications being taken exactly as prescribed. If you are unsure of how to take any medications, please talk to your PCP, and/or staff about your questions, make sure all of your questions are answered.

Stress: Avoiding stress is easier said than done, but try to find ways to relax. Talk to your PCP about stressors in your life.

Monitor your Blood pressure: Measure your blood pressure, document it daily and bring your blood pressure record to every PCP appointment.

Do not take Motrin, Advil, Aleve or other Nonsteroidal anti-inflammatory drugs (NSAIDs). This is a type of medication that increases and aggravates heart disease. Speak to your PCP before taking any pain medication other than Acetaminophen to avoid complications. Your doctor will let you know what is safe to take and how often.

Encounter for screening, unspecified:
Alcohol Screening Performed on 12/17/2018.
Alcohol Screening
1. How often do you have a drink containing alcohol? Never
2. How many standard drinks do you have on a day when you do drink?
3. How often do you have six or more drinks on one occasion?
AUDIT C TOTAL SCORE: 0
4. How often during this last year have you found that you were not able to stop drinking once you had started?
5. How often during this past year have you been unable to do what is normally expected because of your drinking (work, pay bills, etc.)?
6. How often during the last year have you needed a first drink in the morning to "get yourself going" after heavy drinking?
7. How often over the past year have you had a feeling of guilt or regret after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been hurt as a result of your drinking?
10. Has anyone been concerned about your drinking or suggested you cut down?
11. Alcohol Education/Intervention:
Advised patient on the following:
Alcohol/Drug and Medication Education provided.
Note/Comment:

Other Plan/Conclusion
WELL ADULT EXAM
RTC 1 WEEK FOR LAB RESULTS
CHECK CBC, CHEM, UA, TSH,
REVIEW OF REGULAR HEALTH MAINTENANCE ISSUES ALONG WITH PT EDUCATION:
-MAMMOGRAM SCREENING] 40 YRS OLD
-REFER TO GYN FOR PAP SMEAR
-SMOKE DETECTORS
-FIREARM SAFETY/INJURY PREVENTION
-DOMESTIC VIOLENCE SCREENING
-SEAT BELTS
-TOBACCO/ALCOHOL/DRUG USE
-MENTAL HEALTH
-CONDOM FOR SAFE SEX

Depression Screening performed on 12/17/2018
Depression Screening (PHQ 2 and PHQ 9)
Over the past 2 weeks, have you often been bothered by:
1.Little interest or pleasure in doing things? No
2.Feeling down, depressed, or hopeless? No
PHQ 9 Screening Negative Screening
Procedure:
ASSESSES PATIENT/FAMILY/CAREGIVER'S:

ABILITY TO UNDERSTAND CONCEPTS AND CARE REQUUIREMENTS ASSOCIATING WITH MANAGING PATIENT'S HEALTH: YES

PATIENT VOICES UNDERSTANDING OF ALL CONCEPTS DISCUSSED DURING THEIR VISIT INCLUDING CARE MANAGEMENT, MEDICATION, PATIENT EDUCATION: YES

INCORPORATE PATIENT PREFERENCES AND FUNCTIONAL/ LIFESTYLE GOALS: YES
IDENTIFIES TREATMENT GOALS: YES
ASSESSES AND ADDRESSES POTENTIAL BARRIERS TO MEETING GOALS: N/A
PROVIDE A WRITTEN SELF- MANAGEMENT PLAN: YES

MEDICATION MANAGEMENT
REVIEW AND RECONCILE MEDICATION: YES
PROVISE INFORMATION ABOUT NEW PRESCRIPTION: (NO NEW MEDICATION)
ASSESSES UNDERSTANDING OF MEDICATION: YES
ASSESSES RESPONSE TO MEDICATION AND BARRIERS TO ADHERENCE: YES

PROVIDE EDUCATIONAL RESOURCES TO PATIENT: YES
PROVIDE SELF-MANAGEMENT TOOLS TO RECORD SELF-CARE RESULTS:YES

Attending Provider: CHAN, CHUN-KIT, MD, Covering Provider: CHAN, CHUN-KIT, MD
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